

Maryland Cancer Plan
Prostate Cancer Committee- Draft Recommendations

A) Overarching Recommendations:

1. Disseminate/promote Minimal Elements from Medical Advisory Committee.
2. Professional education of health care providers regarding prostate cancer screening and the Minimal Elements document.
3. Increased focus on minority men and high risk groups to determine how culture affects screening and treatment decisions (also research).
4. Materials for prostate cancer education and decision-making should be translated into other languages.
5. Involve a spokesperson or role model for the issues surrounding prostate cancer.
6. Education of the public about prostate cancer as a disease.
7. De-emphasize screening and promote education regarding other prostate cancer control mechanisms such as risk awareness.
8. Public education and awareness needs to be increased.
 - should include spouses of patients
9. Accurate health messages and findings disseminated to public; avoid media sensationalism of new findings and communicate actual meaning.
10. Use libraries to disseminate information via computers/internet.

B) Primary Prevention:

11. Determine message that should be conveyed regarding primary prevention.

C) Secondary Prevention:

12. Men should be provided with up to date information regarding the benefits and harm of screening.
13. Pros and cons of screening should be conveyed to all patients, health professionals, and community leaders.
14. Promote informed decision-making prior to screening, including that there are multiple options for message delivery (i.e. the physician does not necessarily have to be the vehicle for health education).
15. Make signature of informed consent mandatory for prostate cancer screening.
16. Legislation requiring informed consent for prostate cancer screening, or another mechanism to encourage informed decision-making.

17. Strong differentiation between screening and treatment.
18. Mandatory second opinion after screening.
19. Ideally, all screening should occur in a clinical setting OR there must at least be some provision for treatment.
20. Both PSA and DRE should be included in any screening.

D) Tertiary Treatment & Care:

21. Educate men about clinical trials and observational research.
22. Educate men about post-screening options.
23. Enhanced training for urologists and/or other providers to minimize the side effects of prostate cancer treatment. First conduct an outcomes analysis to examine the scope of the problem in Maryland.
24. Collection and dissemination of information on support groups and resources for men with prostate cancer.
25. Support groups for spouses/significant others.
26. All patients who are screened must be linked to follow-up and treatment services. Perhaps require institutions doing screenings to establish a protocol for this linkage to treatment, as suggested in the Minimal Elements document.
27. Involve survivors as patient navigators.
28. Men are provided with information about all options for treatment.

E) Research:

29. Recommend participation in clinical trials and promote further funding for all types of research related to prostate cancer.
30. Education regarding participation in clinical trials and observational studies related to primary prevention.
31. Formation of a group to monitor and communicate the state of the art in prostate cancer.
32. Research into screening in a clinical setting vs. a non-clinical setting.
33. Clinical trials to determine the extent to which screening or not screening is beneficial.
34. Encourage researchers to look into important areas such as risk factors, new screening tests/mechanisms (or encourage research in all areas of primary, secondary, and tertiary care); support funding for this research.
35. Encourage research into psychosocial aspects of prostate cancer.
36. Encourage research into biochemical failures after apparent cure of prostate cancer.